CITY OF CHICOPEE DEFERRED COMPENSATION PLAN
MANDATORY OBRA PARTICIPANT ENROLLMENT

Account Number **60060-002-001**
Enroll: ☐ OBRA Employee

Name _____ _____ _____
first middle last

Address _____
street

_____
city state zip

E-mail Address _____ Birth Date: _____
mm/dd/yyyy

Social Security No. _____

Marital Status: ☐ Married ☐ Not Married or Legally Separated Sex: ☐ Male ☐ Female

TO BE COMPLETED BY YOUR COMPANY'S PLAN ADMINISTRATOR

Hire Date: _____ Plan Entry Date: _____
mm/dd/yyyy mm/dd/yyyy

Total Years of Service as of the end of the prior computation period: Date:
Payroll Frequency: ☐ monthly (12/year) ☐ semi-monthly (24/year) ☐ bi-weekly (26/year) ☐ weekly (52/year)

PAYROLL DEDUCTION AUTHORIZATION

BEFORE-TAX CONTRIBUTION: 7.5% Mandatory Salary Reduction

This Agreement is made between me the Participant and my Employer with respect to my participation in the City of Chicopee Deferred Compensation Plan. I understand that the information above will remain in effect until changed by me. I also understand that I am required to contribute at a rate of 7.5% until my status as an OBRA employee is otherwise changed.

I understand that in the event of my death, my deferred compensation benefit will be payable to my designated beneficiary.

INVESTMENT SELECTION

7.5% Mandatory Salary Reduction amounts will be invested in the Fixed Interest Blend account

BENEFICIARY DESIGNATION **Check either box 1 or 2.**

Primary Beneficiary: (Check either Box 1 or 2)

1. ☐ **Spouse Primary Beneficiary:** I designate my spouse to receive my entire Account balance upon my death.

   Spouse's Name: _____

   Spouse's Birth Date: _____ Social Security No. _____
   mm/dd/yyyy

2. ☐ **Non-Spouse or Multiple Primary Beneficiaries:** I designate the following person(s) to receive my Account balance upon my death: (Write in whole percentages totaling 100%.)

Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent
Name	Relationship	Social Security #	Percent

SIGNATURE

Participant

Date